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Introduction

Posttraumatic stress disorder and Operations Enduring Freedom and Iraqi Freedom: Progress in a time of controversy

Since its inclusion in the Diagnostic and Statistical Manual for Mental Disorders, 3rd edition (DSM-III; APA, 1980) in 1980, PTSD has been surrounded by considerable controversy. Among other things, critics have charged that the diagnosis (a) pathologizes the normal stress response and overshadows the fact that most individuals are resilient to, or readily recover from, the effects of psychological trauma (e.g., Bonanno, 2004), (b) is not a valid syndrome, but instead a construct created to appease various special interest groups, and (c) requires clinicians to draw a causal link between PTSD and trauma exposure, although in many cases this judgment may be difficult or impossible to make (e.g., Breslau & Davis, 1987).

Notably, the controversy over PTSD has gained strength in recent years. A recent issue of the *Journal of Anxiety Disorders* was devoted to “Challenges to the PTSD construct and its database” (Rosen & Frueh, 2007) and a recent paper in this journal reviewed the evidence for the core assumptions of the PTSD diagnosis and asserted that these assumptions lacked consistent empirical support (Rosen & Lilienfeld, 2008). Much of this recent attention to the validity of the PTSD diagnosis is in anticipation of the upcoming fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-V). It also follows longstanding concern about the potential exaggeration or outright fabrication of many Veterans’ combat and associated PTSD symptom reports (Burkett & Whitley, 1998; Frueh et al., 2005; Young, 1995). This concern initially arose in the wake of the findings of the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990), a congressionally mandated population study of the prevalence of military-related PTSD among Vietnam Veterans, which found that 15.2% of Veterans had PTSD at the time of the study and that 30.9 had PTSD at some point during their lifetime. Some believed that, for a number of reasons, the NVVRS may have overstated the prevalence of PTSD among Vietnam Veterans (e.g., McNally, 2006, 2007; Satel, 2006c). Some have even gone further, suggesting that the misdiagnosis of PTSD among Veterans has promoted compensation seeking and illness behavior while diminishing engagement in treatment because Veterans fear loss of compensation (Frueh, Grubaugh, Elhai, & Buckley, 2007) and have called for corresponding changes to the Department of Veterans Affairs (VA)’s disability policies and procedures and treatment programs (e.g., Buckley, 2007; Frueh, 2007; Satel, 2006a,c).

These longstanding concerns were exacerbated by the results of a 2005 report from the VA’s Office of the Inspector General (OIG) that the number of military service Veterans receiving compensation for PTSD increased significantly between 1999 and 2004, growing by almost 80%, from 120,265 to 215,871 cases (Department of Veterans Affairs [DVA], 2005). This report stated that, during this period PTSD benefit payments increased 149% (up to

over \$4 billion annually), whereas compensation for all other service related disabilities increased by only 42%. Further, the report noted that although compensation for PTSD represented only 9% of all the claims, those receiving compensation for service connected PTSD received almost 21% of all compensation benefits. For some, the results of the OIG report provided confirmatory circumstantial evidence that military-related PTSD is over diagnosed among service members and Veterans (McHugh & Treisman, 2007; Satel, 2006a,b,c).

At the same time that questions about both the validity of the PTSD construct and symptom reports of returning servicemen and women are being debated, other research is suggesting that PTSD may be a highly prevalent disorder among those returning from current military deployments. For example, Hoge, Terhakopian, Castro, Messer, and Engel (2007) found that, using a screening instrument, 16.6% of over 2800 soldiers deployed to Iraq met criteria for PTSD. PTSD was significantly associated with lower ratings of general health, more sick call visits, more missed workdays, more physical symptoms, and high somatic symptom severity. This was true even after the effects of being wounded or injured were controlled in statistical analyses. A recent report by RAND found that of 1,965 military personnel previously deployed to Iraq or Afghanistan, 14% screened positive for current PTSD. The report further suggested that, of the nearly 1.7 million military personnel that had taken part in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), about 300,000 may currently suffer from PTSD or major depression. Importantly, it has been speculated that these estimates may actually minimize the real number of military personnel and Veterans suffering from PTSD and other disorders due to the fact that disclosing mental health difficulties may lead to removal from military duties, ruin the prospects for a military career, or delay a return to home. Nonetheless, on the basis of the available research findings, PTSD has been referred to as one of the “signature injuries” of the active duty service men and women who are deployed to Afghanistan or Iraq (Altmire, 2007).

The current conflicts in Iraq and Afghanistan are unlike others we have witnessed in terms of service personnel being routinely deployed for multiple tours of duty that are longer in duration than those of previous military conflicts, with shorter intervals between deployments. In addition, due to advancements in military technology, many military personnel are surviving their combat injuries at a much higher rate than personnel in previous wars. Although we have some evidence that the rates of psychological difficulties among returning military personnel and Veterans are substantial (Hoge & Castro, 2006; Hoge, Auchterlonie, & Milliken, 2006), we do not yet fully understand

the psychological ramifications of these unique features of the current wars. However, given that some previous research has shown a dose-response relationship between severity of exposure and onset of PTSD (Dohrenwend et al., 2006; Hoge et al., 2004; Norris, Friedman, & Watson, 2002; Schlenger et al., 1992), we can predict that the physical and mental health needs will be greater than what we have seen among previous cohorts of Veterans.

In response to these recent estimates of PTSD prevalence among military personnel deployed to OEF or OIF, the Department of Defense (DoD) and VA have acted by increasing the number of available mental health providers, instituted mandatory primary care screenings for PTSD and other associated disorders, disseminated evidence-based treatments to front line providers, and created important outreach services (e.g., crisis phone lines, online services, telehealth service options) for military personnel and Veterans. In addition to these valuable clinical services, these government agencies have led the way in research efforts. For example, the DoD has provided \$300 million to study PTSD and traumatic brain injury (TBI) among returning service members and Veterans. Both agencies have funded groundbreaking prospective research which will increase our understanding of the risk and protective factors related to PTSD, as well as research on the development of innovative treatments for PTSD and other important issues such as military sexual trauma and how military-related PTSD affects the family unit.

The articles in this special issue review and examine what we have already learned about PTSD and its correlates among those who have returned from their duties in Iraq and Afghanistan, as well as provide an agenda for much needed additional research on the various topics addressed. Just as important, they are also meant to heighten the awareness of both mental health professionals and the public alike about one of the "invisible wounds" (Tanielian & Jaycox, 2008 p. xix) of the wars in Iraq and Afghanistan. Although the current concerns about the validity of the PTSD diagnosis and PTSD symptom reports among Veterans of military service are themselves valid, they must be offset by substantial efforts to more clearly understand the phenomenology and etiology of the disorder among military personnel and Veterans. These ongoing conflicts have also dramatically increased our need to accurately and efficiently identify and effectively treat PTSD among returning Veterans using evidence-based assessment methods and interventions.

By the end of 2006, more than one-third of our military personnel were separated from their service and eligible for compensation and disability benefits. Given recent estimates of the number of military personnel who are experiencing PTSD and other associated problems, the likelihood that the current estimates minimize the actual number of individuals who are suffering from PTSD, and the possibility that PTSD cases may not develop until some extended time after return from deployment (Gray, Bolton, & Litz, 2004; Port, Engdahl, & Frazier, 2001), it is likely that concerns about the extent of the PTSD problem among returning service members and Veterans and how these individuals are treated in the wake of their service will persist for years to come. Importantly, from previous research, it is evident that the post-trauma environment can either buffer or exacerbate the suffering of trauma survivors (Ozer, Best, Lipsey, & Weiss, 2003). As such, we need to exercise great care in how returning military personnel and Veterans are treated.

Throughout the history of clinical psychology, our field has witnessed dramatic advances in assessment and treatment practices resulting from military needs (Benjamin, 2005). Clinical psychologists became recognized for expertise in assessment as a result of developing measures designed to screen out those who might be unfit for military duty and assess aptitude for various military occupations during World War I. Our field was challenged again when large numbers of Veterans returning from World War II presented with various post war difficulties, including what was

then termed "combat fatigue." Psychologists demonstrated that they were able to competently provide much needed psychotherapy services to returning Veterans and, as a result, the federal government encouraged the Veterans Administration and United States Public Health Service to work with the American Psychological Association to encourage the development of more clinical psychology training programs in order to handle the overwhelming need for psychological services for Veterans. Like then, this is a challenging time for our field. As in the past, we must serve the healthcare needs of the men and women who have served our country.

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